Laser Therapy for Skin Treatments

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Effective Date	5/2008
Next Review Date	6/15/2024
Coverage Policy	Surgical 58
Version	4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Laser Therapy for Skin Treatments.

Description & Definitions:

Laser therapy is the use of specific wavelengths of light as medical treatments for various skin/medical conditions.

Criteria:

Laser therapy for skin treatments is considered medically necessary for **1 or more of the following:**

- **Initial excimer and pulsed dye laser treatment** for mild to moderate localized plaque psoriasis is considered medically necessary with **All of the following:**
  - Affecting 10 percent or less of body
  - Failed to adequately respond to three or more months of single/combo topical treatments including **1 or more of the following:**
    - Corticosteroids
    - Vitamin D derivatives
    - Calcipotriene
    - Retinoids
    - Tazarotene
    - Anthralin
    - Tar preparations
    - Keratolytic agents
    - Salicylic acid
    - Lactic acid
    - Urea
- **Repeat Excimer and pulsed dye laser treatment** for mild to moderate localized plaque psoriasis is considered medically necessary with **All of the following:**
  - No more than 13 laser treatments per course or three courses per year
  - Individual has responded to initial course of laser therapy as documented by a reduction in Psoriasis Area and Severity Index (PASI) Score or other objective response measurement

- **Initial Excimer laser therapy for the treatment of vitiligo** with **all of the** following:
    - Failed to adequately respond to medical therapy including **all of the** following:
        - An eight week trial of one topical corticosteroid
        - A twelve week trial of one topical calcineurin inhibitor (e.g., tacrolimus 0.03% or 0.1% ointment, pimecrolimus 1% cream)
- **Continued Excimer laser treatment for vitiligo** is considered medically necessary with **All of the following**:
    - Up to 200 total treatments
    - Individual has documentation showing favorable clinical response to initial course of excimer laser therapy
- **Pulse dye laser treatment** is considered medically necessary for **1 or more** of the following**:**
    - Verrucae when standard treatments have failed
    - Keloids or other hypertrophic scars which are secondary to an injury or surgical procedure with **1 or more** of the following**:**
        - Results in substantial loss of function
        - Keloids/Hypertrophic scars cause substantial pain necessitating constant pain relief medication.
    - Numerous glomangiomas superficially located in the face and neck where surgical removal is not feasible.
    - Pyogenic granuloma in the face and neck
    - Genital warts when home therapy with **1 or more** of the following has been unsuccessful:
        - Podophyllotoxin
        - Imiquimod
    - Granuloma faciale
    - Multiple superficially located port wine stains and other hemangiomas in the face and neck where surgical removal is not feasible
- **Ablative Fractional Carbon Dioxide Laser Therapy** is considered medically necessary for **all of the following**:
    - Scar revisions post burns with **all of the following**:
        - Procedure is being done by a plastic surgeon
        - Individual has functional impairment
        - Individual has tried and failed **1 or more** of the following:
            - Silicone gel
            - Pressure garments
            - Sheeting
- **Carbon Dioxide laser treatments** are considered medically necessary for **1 or more** of the following**:**
    - Removal of superficial basal cell carcinomas of the skin
    - Removal of actinic keratosis when failed treatments include **1 or more** of the following**:**
        - Topical imiquimod or 5-fluorouracil with or without tretinoin cream
        - Cryosurgery with liquid nitrogen
        - Curettage or excision when squamous cell carcinoma is suspected
        - Failed adequate response of **1 or more of the following:**
            - Chemical peel
            - Dermabrasion
            - Photodynamic therapy
- **Yttrium aluminum garnet** (YAG) Laser Therapy for **all of the following**:
    - Hidradenitis Suppurativa

Laser therapy for skin treatments is considered is considered **not medically necessary** for any indication, to include but not limited to:

- **Carbon Dioxide (CO2) Laser for Hailey-Hailey Disease**

Coding:

Medically necessary with criteria:

Coding	Description
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm
97039	Unlisted modality (specify type and time if constant attendance)
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional Improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Considered Not Medically Necessary:

Coding	Description
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2023: June
- 2021: July
- 2020: July
- 2019: October
- 2015: May
- 2012: May
- 2011: May, October
- 2010: May
- 2009: May

Reviewed Dates:

- 2022: June
- 2019: February, June
- 2018: November
- 2017: January, November
- 2016: May, October
- 2014: May
- 2013: May

Effective Date:

- May 2008

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Laser, therapy, pulsed, dye, wart, verrucae, psoriasis, port, wine, carcinoma, basal, squamous, actinic, keratosis, superficial, hemangioma, granuloma, glomangioma, keloid, hypertrophic, SHP Laser Therapy, SHP Surgical 58, photobiomodulation, EXTRAC Excimer Laser, XeCl Laser, Excimer Laser, Pyogenic granuloma, Genital warts, Granuloma faciale, port wine stains, YAG Laser therapy, Hidradenitis Suppurativa, Psoriasis Area and Severity Index Score, PASI, yttrium aluminum garnet, Excimer Laser Therapy, ELT, Pulse dye laser treatment, Ablative Fractional Carbon Dioxide Laser, Carbon Dioxide laser, Yttrium aluminum garnet Laser, YAG